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INFLAMMATION AND ABSCESES OF THE LUNG CAUSED BY CLOSURE OF THE PRIMARY BRONCHUS.

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BY CALVIN ELLIS, M.D.

ON February 29th, 1856, an intemperate woman was brought to the Massachusetts General Hospital, with a fracture of the left tibia and fibula, and a great effusion of blood into the thigh. With the exception of a tendency to delirium tremens, nothing remarkable occurred, until March 17th, when she was reported to have coughed much in the night. On the following day, dulness and bronchial respiration were detected in front, over the left side of the chest. The tongue was brown, dry and cracked. Pulse 80. On the 19th, the physical signs remained the same, and the patient declared that the expectoration had been of a reddish color, but nothing of the kind was seen by the nurse or house-surgeon. Its appearance was not at this time, nor afterwards, in any way remarkable. On March 27th, the upper part of the left side of the chest, as she lay in bed, was more resonant, but on sitting up the dulness became universal. The prostration at first was such that the back could not be examined, but bronchophony was now heard in the upper part, where there was an absence of fremitus. On June 24th, the resonance was reported as much more marked in the left side of the chest. Here the record of the physical signs ceased. The cough in the mean time had been occasionally troublesome, but was not generally so. During two or three days, in the early part of April, there was considerable heat of the skin, and the patient was, a number of times afterwards, troubled with profuse perspiration. The pulse generally varied from 82 to 96. Pain was several times complained of in the lower part of the left chest, but, judging from the record, this was neither a prominent nor frequent symptom.

From the first the debility was marked; but, as the fractured bones united, she was able to move about on crutches. On June 29th, however, the pulse became quick, the perspiration profuse, and she was confined to her bed. On the 30th of August she was

able to sit up, but on Sept. 5th there was a marked loss of strength and appetite. On the 7th, she had a violent paroxysm of cough, raised herself in bed, expectorated two ounces of blood, and then expired, her mouth being filled with a dark, dirty fluid.

Autopsy, 11 hours after death. The *dura mater* was flaccid. Attached to, but easily separable from, the under surface of that portion covering the convexity of the brain, was a pretty firm, yellowish-white, semi-gelatinous layer, about a line in thickness. There was more serum than usual beneath the arachnoid. The substance of the *brain* was rather soft.

The upper and posterior part of the *left lung* was firmly adherent to the parietes, the uniting membrane being very old and strong. The remaining cavity was lined with an old, thick, irregular false membrane, within which were found three pints of pus. Floating in this were a number of long cylindrical coagula, evidently recent, and moulded in some narrow passage. Several of these were also found hanging from openings in the false membrane, through one of which a probe passed into a cavity in the lung, to be described hereafter. The *arch of the aorta* was considerably dilated. In the descending portion was an abrupt aneurismal dilatation, perhaps two inches in diameter, with a smooth, well-defined mouth of about half that size. At the bottom of the sac was an opening through which a probe passed into the left primary bronchus, at a point between two and three inches from the bifurcation of the trachea. Above the opening was an old pale-red coagulum, which had apparently closed the passage, but the blood from the ruptured aneurism had forced its way into the trachea. The *bronchi* contained many coagula, and much dirty brownish fluid. The *lung* was but five inches in length. Scattered throughout its substance were cavities from three lines to an inch in diameter, communicating freely with the bronchi, with the mucous membrane of which their rough, ragged walls were continuous. They also contained much dirty brownish fluid and coagula. The intervening substance was quite firm, and of a dark-gray color, looking very much like pumice-stone. There was no tuberculous disease; no pneumonia; no gangrenous odor. It was evident that the coagula found in the pleural cavity had the same source as those in the air passages.

Two ounces of serum existed in the *right pleural cavity*. The *right lung* was very large and fully distended with air. In its substance were many bloody spots, evidently owing to the entrance of blood into the bronchi. The *pericardium* contained about two ounces of whitish serum. The *heart* was flaccid. Blood thin.

There was one pint of serum in the *peritoneal cavity*. The *arch of the colon* was adherent to the parietes.

The *spleen* was of large size; weight, $10\frac{1}{2}$ ounces.

The *kidneys* were large.

The condition of the lung was considered very interesting in connection with the closure of the primary bronchus. It may, however, be maintained that, as the rupture took place below the

coagulum and was followed by hæmoptysis, there could not have been complete closure; but it is evident that the blood forced its way beyond the obstruction, at the time of the accident, as it was only after this that the mouth was filled with the dirty fluid, found in such abundance throughout the lung. Nor is the existence of bronchial respiration incompatible with complete closure, for it is well known that sounds formed in one side of the chest may be heard in the other, and the dense tissue of the left lung might readily transmit a sound formed in the lower part of the trachea or right primary bronchus.

The appearances, in this case, recalled a similar one, seen a number of years since. The examination was made by Dr. J. B. S. Jackson, to whom I am indebted for the following facts.

The patient was perfectly healthy before his last illness, and was engaged in active business, in which he had exerted himself more than usual. While in California, in the latter part of May, 1848, he went to bed as well as usual, and awoke in the morning with dyspnoea and a sense of oppression about the upper part of the sternum, symptoms which never afterwards disappeared. On Dec. 10th, he returned to Boston, having borne the journey across the Isthmus pretty well, though much reduced in general health. Examined three days afterwards, the pulsations of the heart were felt more towards the right side than usual. The pulse was the same in both wrists. A pulsating tumor or fulness was found about the cartilage of the second left rib, where there was dulness on percussion. The respiration was feeble over the whole of the left side of the chest, and a click was heard in forced inspiration.

During the last three months of his life he was confined to his bed, lying most easily on his back, the dyspnoea not being urgent, though increased if he sat up in bed. Through the winter, there was a slight cough, attended by a little frothy expectoration.

Five weeks before his death he suddenly raised half a pint of pus, and from that time expectorated the same copiously. He would sometimes speak of oppression in his chest, turn upon the right side, expectorate a large quantity of pus, obtain relief, turn back and go to sleep. The tumor about the second rib disappeared after the pus was first raised, and never returned.

Two weeks before death an abscess pointed, not far from the outside of the left nipple. On the following day it was punctured, and about a quart of offensive pus discharged. The expectoration then ceased. Finally, on the 6th of April, 1849, after being raised in bed by an assistant, he expectorated a little blood, a gurgling was felt in his chest, and he expired; two or three ounces of fresh, frothy blood flowing from the external opening.

At the examination, the body was found much emaciated.

Rising from the arch of the aorta, and involving the whole circumference with the exception of a strip, perhaps three fourths of an inch wide, from which the pervious brachio-cephalic trunks arose, was a rounded aneurismal tumor, of the size of an orange. Its

cavity was filled with fibrine, whitish, in layers and rather soft. The parietes of the sac were, in some parts, continuous with those of the aorta, and contained many patches, presenting the same appearance as the wall of the vessel itself. In some places the parietes were entirely destroyed, and, where the sac approached the left primary bronchus, it had sloughed, or was about sloughing, to the extent, perhaps, of three fourths of an inch.

The right branch of the *pulmonary artery* was much compressed.

The *left lung* was the seat of an abscess extending from the apex to the base, containing a thick and rather bloody fluid. What little remained of the lung consisted of a solid, crumbling, gray substance, projecting most irregularly into the cavity of the abscess. There was no gangrene, nor any offensive odor. The pleural cavity was entirely obliterated.

The *left primary bronchus* must have been pushed back, as it was cut into during the removal of the œsophagus. The parietes were soft and discolored, and the cartilaginous rings to a considerable extent detached, standing up like the ribs of a boiled fish. The lower portion of the trachea was of a deep-red color, and the seat of what appeared to be minute ulcers.

In the *right pleural cavity* were about three pints of fluid. The lung contained a few gray granulations in the upper half, but was in other respects healthy.

The other organs were not remarkable.

In remarks appended to this case, the peculiar condition of the lung and its connection with closure of the bronchus, are particularly alluded to by Dr. Jackson, who refers to a similar case which occurred in the Hospital many years before, an account of which will be given next week.

A CASE OF DEATH FOLLOWING DELIVERY.

BY A. NEWMAN, M.D., ATTLEBORO', MASS.

[Communicated for the Boston Medical and Surgical Journal.]

Mrs. MARY D—, 21 years of age, was taken in labor with her first child, Tuesday evening, Oct. 14th. At one o'clock, Wednesday morning, I was summoned to attend her. I was informed that she had had a chill in the early part of the evening. Two years ago, I attended her through a severe attack of peritonitis. Convalescence was accompanied by diarrhœa, which continued for several weeks, and since then she has been subject to alternate states of constipation and diarrhœa. She has suffered much during pregnancy, from pain in the abdomen and especially through the hips; and for the last few days the pain has been accompanied by very great tenderness of the abdomen. The presentation was natural, and nothing unusual was noticed in the progress of labor except that her pains did not intermit. Between the regular paroxysms of

labor pains, she complained of severe and constant pain. The child was born at 8 o'clock, Wednesday morning. Delivery was followed immediately by a chill, which lasted but a few minutes; and this was succeeded by another chill a few minutes after. She did not express herself as having experienced any relief from pain upon the occurrence of delivery, but in answer to my inquiry, said her pain was still dreadful. Upon putting my hand on the abdomen to ascertain the condition of the uterus, I found it so excessively tender, that the least pressure could not be endured. Pulse 96. She was put to bed, and a third of a grain of sulphate of morphia was administered at once, with directions to repeat the dose in two hours if she was not decidedly easier.

11, A. M.—But little easier. Pulse 104. To continue the morphia every fourth hour, and have warm fomentations to the abdomen.

3, P. M.—Pain still severe and extending over the whole abdomen. The patient compares the pain to the cutting of knives. Abdomen excessively tender. She cannot bear the slightest motion. Great and increasing tympanites. Respiration painful, slightly increased in frequency. Thirst. Tongue covered with a white moist coat. No nausea. Pulse 120. Bled from the arm with relief of pain. Ordered leeches, to be followed again by the warm fomentations. Continued the morphia.

In the evening, Dr. S. Clapp, of Pawtucket, saw the patient in consultation, and advised no change in the treatment.

16th.—Has slept. Pain and tenderness less. Tympanites very great. Pulse 116. The patient was unable to pass urine last evening, and the catheter was introduced. She passed urine last, a short time before delivery. To have a blister, four inches by eight, below the umbilicus, and continue the previous treatment.

17th.—Pulse 116. Pain and tenderness about as yesterday. Tympanites very great. Catheter was again introduced, about 4 o'clock yesterday afternoon. To have a blister of the same size as yesterday, immediately above the umbilicus. The warm fomentations to be continued, and the morphia given as before.

Evening.—Pain increased. Very severe through the hips. Occasional regurgitation of a colorless fluid from the stomach. Pulse 120. Introduced the catheter. Urine about normal in appearance. Continue the treatment, diminishing the interval between the powders, to three hours.

18th.—Regurgitation of fluids increased. Pain still severe at times. Pulse 120. Introduced the catheter. Continue the treatment.

3 o'clock, P. M.—Pain very severe. Passed her urine voluntarily, this forenoon. Has taken no medicine for several hours. Gave a powder of sulphate of morphia at once. My homœopathic friend, Dr. Sanford, was present when I entered the room, and after the morphia had been administered, I was informed by the husband that it was the wish of the friends that he (Dr. S.) should

take charge of the patient. He accordingly did so, but I continued my visits for the purpose of watching the progress of the case and noting the symptoms as they occurred.

19th.—Pulse small, fluttering. Pain very severe all night. Delirium. Feet cold. About midnight, the attendants say she threw up a large quantity of greenish fluid. It was ejected from the mouth with considerable force, and seemed to be rather an act of regurgitation than of vomiting. I was informed that the warm fomentations had been exchanged for cold applications and cold water injections freely used.

Evening.—I was informed that the patient had refused to take any more homœopathic medicine. She is now perfectly rational. Is throwing up large quantities of a greenish-black fluid, with great distress at the stomach and through the bowels. Complains at times of a "dreadful throbbing and heat" in the bowels. Feet and legs cold nearly to the knees. Pulse too small to be counted.

20th.—Slept little if any; hands cold and purplish. Pulse barely perceptible; distress severe; regurgitation of fluid, considerably darker in color, continues. Mind continues perfectly clear. Has taken no medicine of any kind since yesterday afternoon.

Evening.—Has taken, this afternoon, three doses of sulphate of morphia of one third of a grain each. Has had two or three copious discharges from the bowels, with considerable diminution in the size of the abdomen. Has been complaining of a feeling of great distress in the throat, for which she is eating ice freely, and with evident relief. No perceptible change in the pulse, or in the condition of the extremities, since morning.

21st.—Pulse 112, of a fair degree of strength; hands warm; feet still cold, but not above the knees. No regurgitation or vomiting since 10 o'clock last evening. Size of abdomen considerably diminished, and tenderness less. Took two doses of morphia during the night. The attendants say she continued to eat ice with little intermission for several hours before the vomiting ceased. From their account, I should think ten or fifteen pounds a low estimate of the amount eaten in three or four hours.

22d.—Commenced homœopathic treatment again about 10 o'clock yesterday forenoon. The attendants informed me that Dr. S. ordered oil of turpentine to the abdomen, and which was applied. The blisters were still discharging. Pulse 112. Hands and feet warm. Protrudes the tongue with apparent difficulty, and says she feels as though she had no teeth, lips or tongue. Complains much of numbness and peculiar sensations all over the body, and says she feels as though she had no limbs. She expresses herself as feeling as though a heavy weight were pressing her together. Delirium began to come on yesterday afternoon, and has been increasing; from 12 to 4 o'clock this morning, it was violent. She raved much about "burning up."

Evening.—Has slept a little this afternoon. Skin warm. Tongue moist. Pulse 132. Has passed urine two or three times to-day,

and had a large discharge from the bowels ; both passages involuntary. She is mildly delirious.

23d, 8, A. M.—Lies on her back, talking deliriously ; face flushed. Pulse 144, small. She was violently delirious last evening and through the night. No sleep. Discharges from the bowels and bladder involuntary.

Evening.—Tongue moist ; partially covered with frothy mucus. Pulse 160. Feet and hands cold and clammy. Constant delirium. Tympanites increased. Complains often of feeling as though she had no limbs.

24th.—Pulse not sufficiently perceptible to be counted ; lips livid ; hands cold and clammy ; pupils slightly contracted ; tympanites increased. Has had two discharges from the bowels and passed urine several times, all involuntarily. Urine strongly ammoniacal. Two livid spots, about the size of a large pea, appeared, one upon the back of the right wrist, and one upon the back of the index finger of the same hand. I was afterwards informed by the attendants that there were a number of similar spots upon the feet.

Evening.—She has vomited largely once. Pulse imperceptible. Muttering deliriously. Slight convulsions, with muscular rigidity. Died at twelve o'clock. The convulsions recurred several times, but were not severe. No examination was allowed. Dr. J. R. Bronson was associated with me in the management of the case, and rendered valuable assistance.

This case presents several points of interest to my mind, not the least of which is the cessation of the vomiting upon the evening of the 20th, and the great apparent improvement present upon the following morning. This could not be attributed to medicine, as she had taken none, with the exception of a little morphia, for more than twenty-four hours. Another interesting feature of the case is the occurrence of delirium on the night of the 18th ; its disappearance on the following evening, and its return on the afternoon of the 21st ; the patient having been, during this interval, perfectly conscious and rational. In relation to the delirium, the following question suggests itself to my mind. Was it produced by aconite or its active principle, which the symptoms so clearly show to have been administered in most heroic doses ?

[The original management of this case seems to have been judicious. It is not mentioned how many leeches were applied to the abdomen ; from the urgency of the symptoms, we should suppose that a large local bleeding, even earlier in the case, would have been beneficial. We cannot refrain from expressing the opinion that had the physician at first in charge been allowed to attend the patient, uninterruptedly, the result might have been more fortunate. —EDITORS.]

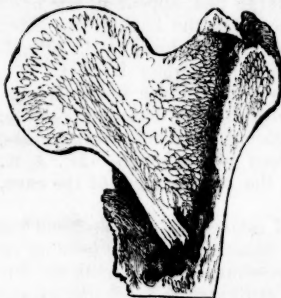
Reports of Medical Societies.

EXTRACTS FROM THE RECORDS OF THE BOSTON SOCIETY FOR MEDICAL IMPROVEMENT. BY F. E. OLIVER, M.D., SECRETARY.

AUG. 11th.—*Impacted Fracture of the Neck of the Femur.* Dr. CLARK showed the specimen and related the case.

The patient was a man 84 years old, who had been hemiplegic for several years. The fracture was produced by a sudden fall upon the trochanter.

Dr. C. found the patient in bed, the foot and leg being slightly everted, with shortening of the limb to the extent of from one half to three fourths of an inch; there was also immobility of the leg, but no crepitus. The patient was confined to his bed for four weeks without any untoward symptom; loss of strength and appetite, however, supervened, and he died in the middle of the seventh week after the accident. The fracture seemed to have united before his death.



On examination *post-mortem*, the fracture proved to be impacted, the fractured portion of the neck having been driven into the trochanter, as is shown in the accompanying drawing.

Dr. JACKSON remarked that he believed cases of impacted fracture of the neck of the thigh-bone are much more common than has been supposed. He alluded to a case which he saw a year and a half before, in which the fracture had occurred from a slight accident. After the death of the patient, which took place in a few weeks, the neck of this bone was found so firmly impacted

as to require a considerable force to dislodge it. There could be, of course, in such a case, no crepitus, nor could the limb be drawn down. This condition would also account for the facility with which patients sometimes walk immediately after this accident.

Dr. H. J. BIGELOW thought impacted fracture of this part probably very frequent. He also stated that he had noticed a *torsion* of the neck of the bone in these cases, as if its posterior portion had been first driven in; a condition to which writers had not adverted.

AUG. 25th.—*Fracture of the Neck of the Femur within the Capsule.* Dr. CLARK showed the specimen and reported briefly the case.

The patient was a fleshy woman, who met with the accident by being tripped by a dog. There was crepitus, *eversion* and shortening. She died at the end of a fortnight, of an affection of the heart, to which she had been subject.



OCT. 27th.—*Ovariectomy.* Dr. GAY reported the case.

The patient, A. L., was aged 26; unmarried; a domestic; born in Ireland. Her health had been generally good until about a year ago, when she was for some time troubled with a sensation of sinking at stomach, occasional vomiting of food and feeling of languor, from which she recovered in the fall.

In January, 1856, while engaged in washing, she got much heated and put off part of her clothing, and was afterwards exposed to the cold, the catamenia being present at the time. During the night she was taken with soreness and swelling of the abdomen, hoarseness and headache. The swelling subsided in the upper part of the abdomen, but continued in the lower part. In a few weeks afterwards she noticed a resisting body in the lower abdomen, which continued to increase till the present time, although slowly of late, with occasional sharp pains and tenderness on deep pressure. The catamenia have always been regular and sufficient. There was a slight show on the morning of the operation, which ceased altogether in about an hour. The urine had been rather scanty and dark colored, but there had been no trouble or unnatural frequency in passing it. Appetite pretty good. At the time of her entrance to the Hospital, July 12th, 1856, the circumference of the abdomen, three inches below the umbilicus, was 33 inches. The tumor was felt distinctly by Dr. STORER, to the right of the median line, movable and surrounded by a liquid, supposed to be ascites.

The patient was transferred from the medical department for an examination, and operation, if deemed advisable. At that time there was considerable distension and prominence of the abdomen up to a line level with the umbilicus, looking like one six or seven months advanced in pregnancy. This fulness was owing partly to the fluid, supposed, of course, to be ascites. A little to the right of the median line, and just above the os pubis, was felt on deep pressure, which was not followed by any pain or soreness, a large, round, hard and movable tumor, partly in the abdominal and partly in the pelvic cavity, elastic, but still not giving a feel of fluctuation. As well as the patient could remember, the position of the tumor was always the same. It could be easily moved from the right iliac over to the left lumbar region, and upwards above the umbilicus. This extensive motion seemed to preclude the existence of any adhesions between the anterior surface of the tumor and the abdominal walls. The adhesions at the base of the tumor were also supposed, for the same reason, and from the indications obtained by a rectal and vaginal examination, to be slight. There was none of the rubbing or creaking sound, as symptomatic of peritonitis. The diagnosis rested between a pure, solid ovarian tumor, and a fibrous tumor of the uterus. On a *vaginal* examination, the *os uteri* was found easily within reach of the finger, of natural size, and turned to the left side. The cervix was of usual length, and the feeling was, as far as the finger could go, that the body of the uterus was not enlarged, and was freely movable to a certain extent independent of the tumor; that is to say, that pressure and motion to the uterus, through the cervix, did not give any appreciable motion to the tumor. On moving the tumor with one hand while the finger of the other hand touched the uterus through the vagina, no more motion was communicated to the uterus, than might be expected from any body of that size, whether connected with the ovary or by a small pedicle with the uterus, but did not seem to be enough for a growth continuous with the uterus, or closely and firmly connected with it. On moving the tumor laterally, some slight downward pressure was almost necessarily

imparted to it and to the uterus, and with it a slight motion. The presence of so large a quantity of abdominal fluid did not allow that thorough manipulation of the tumor, which its absence would have permitted. This helped to obscure and complicate our diagnosis. There was a feeling that the uterus could be moved without giving any motion to the tumor, and that the uterus to a certain extent moved independent of the tumor; but motion to the tumor seemed to move slightly the uterus by dragging or pressure. Scarcely any information was gained by a *rectal* examination.

Ballottement was decidedly present, though this is usually denied. The present instance was particularly favorable for ballottement, as there was a moderately heavy, movable tumor, of the size of a child's head or larger, floating in a liquid, which on being pressed upward while the patient was in the erect posture, immediately fell down upon the finger, precisely similar to the fœtus in utero. There does not seem to be any sufficiently good reason for its not being present in nearly all ovarian growths, at a certain period, and also in pediculated tumors of the uterus. There must be a certain amount of weight and fullness of the cyst, mobility, freedom from adhesion, to render ballottement appreciable. The degree of rising and falling of the tumor will be measured by the presence or absence of one or more of these, and also by the length of the pedicle. Other circumstances being equal, any abdominal fluid will favor it. Ballottement would be next to impossible if there were firm and extensive adhesions, or if the abdominal cavity was filled by the tumor, as in that case there would be little or no mobility, though at the same time there might be no adhesions—(adhesions may and do limit the motion of a tumor in that region, while the absence of mobility may be and is owing to a different cause)—or if there was a large cyst, with a small amount of liquid in it. There does not seem to be any reason for limiting the symptom of ballottement to pregnancy. Of course the tumor must be within good reach of the finger.

The *uterine sound* was passed into the uterus, which was found to be of natural length, with the fundus turned to the right ilium. Neither the fundus nor the extremity of the sound could be felt through the abdominal walls above the pubis, for the very good reason that the whole tumor lay directly upon the *anterior* surface of the uterus. According to Dr. Simpson this is a very important element in the diagnosis, for he says, "*if the sound shows the tumor to lie on the anterior surface of the uterus, the disease may be considered as certainly not ovarian.*" No cause can be assigned for the constant position of the tumor (being the left ovary), to the right of the median line, and upon the anterior surface of the uterus. But the fact remains, and another case may present the same peculiarity. The anterior position of an ovarian tumor with regard to the uterus does not seem at all improbable until the tumor has entirely passed out of the pelvic cavity. The uterus being fixed by the sound, the motion to the tumor from its natural position a little more to the right side, gave the feeling of pressing down the uterus, and also the idea that the uterus was intimately connected with the tumor, if it was not wedged down by it; but on gentle movement of the tumor to the left side, no motion was felt in the uterus till the tumor was over to a certain position, when the handle of the sound turned and moved towards the right thigh. There seemed a motion in the tumor to a certain extent to the left side, without a corresponding one in the uterus. If it had been a fibrous tumor, with a broad and short attachment to the uterus, the motion given to it must have been instantly and decidedly felt in the uterus; but if there was a small, long pedicle, or if it was ovarian,

then the motion would not have been felt so immediately nor so decidedly. In the natural position, no motion could be given by the sound to the uterus towards the left side, or even the median line. A heavy obstacle prevented it. But a slight lateral motion was perceptible towards the right side, as obtained by the finger alone, in the vaginal examination, without any corresponding motion of the tumor. The fulness of the abdomen prevented the very important method of raising upwards the tumor as far as possible, and observing the action upon the uterus. The independent motion, to a certain extent, of the uterus, seemed to show that it was either a pure ovarian tumor, or, if a fibrous tumor, that it was attached to the uterus by a small, long pedicle, and consequently no contra-indication to an operation.

The diagnostic information obtained from the uterine sound, was not so valuable in this particular case, as it undoubtedly has been in many others. Exceptional cases may arise to puzzle every manipulating process. Take the case of an ovarian tumor, with the fallopian tube attached firmly throughout its entire length to some portion of the tumor; or the case of an elongated uterus, firmly and extensively adherent to an ovarian growth; what is there to help us to decide whether it is a fibrous or ovarian disease, for the motion in one must be almost simultaneous in the other? The uterine cavity, though usually normal in ovarian growths, may be elongated, as in fibrous tumors, of which three instances can now be recalled, where the cavity was four or five inches long, and even longer. In these cases of extensive and firm adhesion between the uterus and the tumor, the difficulty of reaching the os uteri increases with the growth of the tumor, so that the os may be beyond the reach of the finger. The chances of success in operative proceedings, when the os uteri cannot be reached by the finger, are unfavorable. While the patient was in the medical department, she daily went about the ward, without any special treatment, and gave no one the slightest cause to suspect anything like peritonitis.

A surgical consultation was held, Saturday, Sept. 20th, 1856. There was another one on Sunday, when the uterine sound was used. On Monday she had some soreness, but no pain. No complaint was made on Tuesday or Wednesday.

These remarks are made in connection with the peritonitis found at the time of the operation.

The day before the operation, an ounce of castor oil was given; and on the morning of the operation, light diet and an enema.

Operation.—Sept. 24th, the temperature was at about 74 degrees in the room. The tumor being pushed to the median line, an incision about six inches long was made from just below the umbilicus to the os pubis, dividing carefully every thing down to the peritoneum. An opening was made in this, and a large quantity of gelatinous fluid, resembling the white of an egg, escaped from the abdominal cavity, evidently ovarian in its character. The quantity was supposed to be about two gallons, which was much greater than was anticipated by any of us. A trocar would have been used, if this amount had been expected. It will be remembered that fluid was apparent in the abdomen at the time of the patient's entrance to the Hospital in July, and Dr. Storer and every one who examined her had no reason to suspect any thing but a peritoneal secretion. At the operation, nothing resembling the peritoneal secretion was observed.

When the fluid was entirely removed, the anterior surface of the tumor was brought into view, exposing a circular, ragged opening, of the size of a half dollar, through which the abdominal fluid, at some former period, had

flowed. It is perhaps somewhat singular that the ragged condition of the opening should have remained so long. When this rupture occurred, or what produced it, cannot be ascertained.

The tumor itself was then brought out of the wound, and it was found to be the left ovary attached to the broad ligament, by a thin, ribbon-like pedicle or base, nearly three inches wide, and lying upon the *anterior* surface of the uterus, which was found perfectly normal. The left fallopian tube, for about three inches, was closely adherent to the base of the tumor. A double ligature was then passed through the centre of the pedicle, and tied each way. A single one was then placed below these, and the tumor removed. Not a single vessel was tied. The part which remained with the ligature attached, was too short to be retained at the external wound. The peritoneal surface of the intestines and abdominal walls was found inflamed, with here and there deposits of soft, recent, milky-white lymph. No adhesions were found at any point. The wound was brought together and supported by six sutures, and adhesive straps between them. Luke-warm-water compresses were applied, covered with oiled silk. No swathe or bandage seemed necessary. Directions were given to keep her sufficiently under the influence of opium, to be given in grain doses every few hours, or oftener if necessary. *Externally*, the tumor was smooth, regular and shining; twenty inches in circumference and four inches through from its anterior to posterior surface; *internally*, it was composed of a number of small cysts, the walls of which were of different degrees of thickness and solidity. The *right* lateral half of the tumor was decidedly twice as *heavy* as the left, which may have some reference to the constant position of the tumor.

Sept. 25.—During the night there was some retching, but no vomiting. Pulse 100, small. Slight flatus. No pain nor soreness. Some hiccough at 2, P. M. At 6, P. M., complained of feeling cold. Some dyspnœa. Pulse 120. Flatus increased. Occasional vomiting. During the straining, a large quantity of a watery liquid was forced through the upper part of the wound. In the night, for the first time, she suffered pain, and gradually failed, and died at 2, A. M., Sept. 26th, about thirty-eight hours after the operation.

On a *post-mortem* examination, the external wound was found firmly united by the first intention, except a small opening at the upper extremity, which was made during the vomiting. The peritoneum was inflamed throughout, and the intestines were all glued together in one mass. The ligature was secure around the pedicle, and there was a tablespoonful or more of a semi-purulent liquid in the cavity of the pelvis. There was no sign of any hæmorrhage.

The peritonitis found at the operation was unexpected, and unquestionably hastened the fatal termination.

After the use of the uterine sound, particularly if in consultation with two or three persons, Dr. Gay remarked that he should decidedly recommend that an interval of a week or ten days should elapse previous to an operation, and also that a frequent external manipulation, by one or more, should be avoided.

Dr. STORER remarked that he thought the result in this case, which seemed a peculiarly favorable one, would cause a greater unwillingness to operate in these cases than had heretofore existed. He questioned whether the peritonitis might not have been induced by the numerous examinations of the patient at the time of the consultation.

Dr. CABOT saw no reason why the ill success of this operation should influence surgeons in any future cases, as the probable cause of death was peritonitis, the presence of which was not suspected; also stating that statistics show this operation to be justifiable.

Dr. BOWDITCH remarked upon the unfavorable result of this operation in hospital patients as compared with private cases, and questioned whether this difference might not be in a degree owing to the greater number of examinations to which the former are subjected.

Dr. Cabot, in reply, was inclined to attribute this difference rather to the fact that few favorable cases are met with at the Hospital.

Dr. MIXER questioned whether the air of the Hospital might not aid in producing unfavorable results in these cases.

Bibliographical Notices.

A Treatise on the Practice of Surgery. By HENRY H. SMITH, M.D., Professor of the Principles and Practice of Surgery in the University of Pennsylvania, &c. &c. Philadelphia. 1856.

WHEN we take up the latest book upon any general subject, we have a right to expect that it will possess advantages over those of a similar character that have preceded it; its author will be supposed to have stated the changes of opinion which have taken place, and brought his work up to the actual state of science, which, in these days, makes so rapid advances and such striking improvements, and not merely followed the routine of older writers, however high may be their authority. If a new book is required, it is in the accomplishment of these very points that the necessity will show itself.

In the book before us, we find but little that can claim to be original, and as little, taken from foreign or American observers, from journals, proceedings of Societies or other sources, not to be found in those compilations on the same subject, already familiar to us. The preface, however, says that it is more particularly intended for the students attending the author's lectures, and undoubtedly its possession will prove serviceable to them in "posting up" for their examination. It is none the less important, though, that they should have a sure guide and some degree of completeness in the generalities they are to learn, even if the details, more properly belonging to monographs, constitute the reading which should occupy the years that ensue upon graduation. The present work has too many inaccuracies and omissions to carry out its alleged purpose of being "a work of reference in the responsibilities of early professional life;" too frequently subjects are passed by or slurred over, and so many little things, the very ones students require to know, are wanting, that we cannot but believe the book has been written in haste, or issued to meet the requirements of the approaching lecture season. It certainly cannot add to the reputation of its author, nor tend to elevate the standard of medical education. We append a few of the notes made in carefully examining this book, and think they will show that the above opinion is not without foundation.

In the chapter on "Malignant deposits or growths," Dr. Smith speaks of cancer of the lip as a "form of cancer comparatively rare" (p. 192); no mention is made in the brief chapter upon this affection, of epithelial disease, nor any where in the book does he treat of, or make a distinction between, epithelial and true cancer. Colloid he considers "merely a degene-

ration of the other forms of the disease" (p. 216). On page 178, he says, "the exciting causes of carcinomatous disorders are blows and such other injuries as develop local inflammatory action in a constitution suited to its formation;" and at page 218, he states, that "with the present knowledge of histology there need be no hesitation in saying that tumors primarily benignant may assume all the characteristics of malignant growths." With regard to enchondroma, it is not so easy to say what is Dr. Smith's opinion, since at page 225 he classes it with benignant tumors, and at page 483 says, "spina ventosa and osteo sarcoma would be better designated as enchondromata, or as cancer of bone." He believes in the specificity of the so-called "cancer cell," and his estimate of the value of the microscope in the diagnosis of tumors, is expressed in the following flattering terms: "The two together (microscopic and clinical observation) are as nearly perfect in their conclusions as our finite senses can make any observation; but either, alone, is liable to mislead the observer, and establish incorrect results" (p. 228). These certainly may be considered inaccuracies, as much as the attributing of the well-known "Baynton's method" of strapping ulcers, to Mr. Critchett (p. 122).

At times, Dr. Smith seems to ignore many methods of treatment that have come in vogue of late, adhering to measures that have, to a certain extent, gone out of use. He makes no mention, for instance, of the treatment of cold abscess by iodine injections. In fractures of the patella, splints and bandages and clamps of all sorts are preferred to simple rest in the horizontal position, with the figure of eight bandage. Kentish ointment, carron oil, paint, &c., for burns, are preferred to less irritating applications, such as gum arabic, of which no mention is made. In the section on hydrocele, the palliative treatment is spoken of, but for any mention of the use of iodine, or anything else in connection with its radical cure, we must see the author's work on *Operative Surgery*. He says nothing about the treatment of lupus; paraphymosis is only named; fistula lachrymalis is treated of in less than four lines. As might be expected, pure sulphuric ether finds no favor with Dr. Smith; he speaks of a mixture of one part chloroform and two parts ether, as being the most appropriate anæsthetic, but to our surprise, he devotes not even a paragraph to anæsthetic agents in general, or to the mode of inducing anæsthesia. In the chapter on special wounds, he enumerates railroad wounds as being peculiar to modern surgery, but says nothing further in reference to them. These are undoubtedly omissions.

Although the book is generally pretty full on the subject of treatment, occasionally, however, it seems to advise what some might consider hyper-medication. The following extract, showing the author's treatment of iritis, will sound, to those who have read Dr. Williams's article on this subject in recent numbers of this Journal, as strikingly in contrast to the simple method, originated and so successfully used by that accomplished oculist. "There is no better remedy than general bloodletting; which, to be truly efficacious, should be prompt and carried to a considerable extent. The medicinal treatment should then be commenced by the administration of a brisk purge; and this, to be serviceable, should contain a mercurial. Mercurials in small doses frequently repeated, and carried to such an extent as to impair the condition of the blood, break down the plasticity of the lymph, and thus diminish or remove the evils consequent upon adhesions of the iris, are also often highly useful; but, in order that their effects may be fully produced, the mercurial should be carried to such an extent as to in-

duce salivation" (pp. 585, 586). From his section on dissecting wounds, we cannot forbear quoting the paragraph censuring a very common practice in the treatment of the little pricks and cuts in which the serious accidents that sometimes follow, usually originate; considerable experience makes us equally confident that it is erroneous, and we have always denounced it in the dissecting room. It is as follows. "A practice which has been highly lauded and often practised, is to cauterize the wound freely with nitrate of silver, so as to produce an eschar. Experience has, however, shown me many cases in which this treatment has increased the symptoms, and I believe it does so in the majority of cases, by adding to the inflammation and irritation of the wound, and by forming a slough, which by preventing the escape of the noxious fluids, favors their absorption, and therefore advise the student to abstain from the use of the nitrate of silver in the early period of this affection" (p. 273).

The best chapters in the book are those on Fractures and Luxations, and on Diseases of the Genito-Urinary Apparatus, and they are most excellent. The illustrations are well selected and add much to its value; many of them are above the average of our ordinary wood cuts. Dr. Smith treats more fully of the principles than the practice of surgery, though the latter is the title of the work; the omission in this latter respect being generally accounted for by a foot note referring to his treatise on Operative Surgery.

R. M. H.

Obstetric Tables by Dr. Pajot, Agrégé Professor to the Faculty of Medicine, Paris. Translated from the French and arranged by O. A. CRENSHAW, M.D. and J. B. McCaw, M.D., Richmond, Va.; with three additional tables on the Mechanism of Natural, Unnatural and Complex Labor. By NATHAN P. RICE, M.D. New York.

THESE tables, eight in number, give an admirable bird's-eye view of obstetrical medicine of the present day. The first is devoted to the signs of pregnancy, classified according to source of the sign, the organ furnishing it, and the means used to elicit it. The authorities for each assertion are here given, as indeed they are throughout the tables, printed in brackets, and we note with surprise the entire absence of the name of Montgomery, whose numerous and precise observations we should suppose would furnish some of the signs and suggestions in this department. We find a name, too, printed in the same type and manner as those of the authors, but which we do not remember to have seen on the title page of any medical book ("Caoutchouc").

The next table exhibits the deformities of the pelvis, and the conduct to be observed in cases in which they exist. This is compiled from the best French and German authorities, and we are happy in the paucity of such malformations amongst us to leave these writers as the best on the subject. The first among the directions for treatment is where the short diameter is $3\frac{3}{4}$ inches, in which it is advised to wait five or six hours after complete dilatation if the head is at the superior strait, and if at the inferior, to wait two or three—then "apply the forceps," the author adding that he directs "to wait as long as the contractions continue and the condition of the mother and child is not dangerous." In a review, some time ago, we gave our convictions upon this subject, and we here repeat that we cannot see the advantage or propriety of delaying relief and prolonging the woman's sufferings, when there is no progress made for a such a period. If there is complete dilatation, why not use the forceps sooner?

The next table treats of hæmorrhage, both before and after labor, and we are glad to see, in the mention of the tampon, a caution against too great reliance upon it, and the mischief it may do pointed out. We have seen enough of its use to feel that if the attendant wants a breathing spell at the bedside of the patient, he may use it, watching all the while, but we should never think of turning our back upon it for ten minutes, or of keeping our finger off the pulse of the patient for five.

The table appropriated to version is concise, but sufficient and very clear; and the same may be said of that exhibiting the cases requiring the use of the forceps, and the directions for applying these instruments.

The next table is by Dr. Rice, giving the rules for the conduct of a natural labor. The only exception we take to this, is the assertion that a cot bed is the best. Besides the smaller size of it and its want of solidity, we consider a foot-post with a sheet tied to it for the patient to pull upon during the pains, as a very important adjuvant. This may be unscientific, and we may be suspected of occasionally advising our patient to blow into her hands to make the after-birth come away, but still we do hold to a foot-post.

False pains we find here attributed to "sympathetic disturbance of the intestines or some of the abdominal viscera." We have found them mostly in the abdominal muscles, but sometimes even in the uterus itself—at least we have had every reason to believe so—an irregular spasm of some of the muscular fibres.

The two remaining tables are given to unnatural (that is, prolonged over twenty-four hours) and complex labors, and seem to furnish all that can be afforded in the space. We have to notice throughout the work an entire absence of any American name as an authority, and we are too much "Native" not to feel that our own authors might be quoted much oftener than they are.

W. E. C.

THE BOSTON MEDICAL AND SURGICAL JOURNAL.

BOSTON, DECEMBER 4, 1856.

THE VALERIANATE OF AMMONIA.

IN our number for Nov. 6th, we noticed a remarkable case of neuralgia cured by the use of the *valerianate of ammonia* in doses of a teaspoonful. This preparation, which is of recent introduction in pharmacy, even in Paris, was entirely unknown to us, when we read the account of its effects in the *Union Médicale*, and we were ignorant that, if given in the above dose, the preparation is an active poison. Shortly after Dr. Declat's paper was published, M. Labourer, an apothecary in Paris, received a prescription for an ounce of this substance, to be taken in the dose of a teaspoonful twice daily. Alarmed at the dose, as well as the form in which the medicine was to be taken, before putting it up he consulted the physician who wrote the prescription. The physician, who had no acquaintance with the properties of the valerianate of ammonia, had prescribed it in a case of neuralgia which resisted all the usual remedies, in the faith of Dr. Declat's recommendation, supposing it to be a liquid preparation, like the acetate of ammonia. It was arranged that half a drachm of the salt should be dissolved in an ounce of distilled water, and the solution administered in doses of a teaspoonful, un-

der which treatment the patient experienced great relief, the dose having been afterwards increased to a dessertspoonful. M. Labourer states that the preparation of the valerianate of ammonia is a long and difficult process, concerning which he intends to give the results of some investigations made by himself and M. Fontaines—results which cannot fail to be interesting, since they relate to a new remedy which appears to promise so much. In the mean time, as it may be difficult to obtain this salt here, we recommend (on the suggestion of Mr. METCALF, of Tremont street) that those gentlemen who are desirous of trying it in cases of neuralgia, should employ the *ammoniated tincture of valerian*, a preparation nearly identical in its essential elements, and which has been given with success in this disease. The dose is half a fluid drachm.

THE ACTION OF ALKALINE MEDICINES ON THE URINE.

AN alkaline state of the urine is a common symptom in many diseases of the urinary bladder, particularly in chronic inflammation of the mucous membrane of that organ, and in cases where an impediment to the free evacuation of its contents causes an accumulation of urine for any length of time. A mistake which is sometimes made in the treatment of diseases accompanied by this symptom, consists in always attributing the alkalinity of the urine to some condition of the kidney or of the system in general. Hence the practitioner endeavors to restore to the urine its natural condition, by the administration of acids; but sometimes the more acids the patient takes, the more alkaline his urine becomes. The fact is, that in these cases, the urine is already too acid when secreted, and acting upon the sensitive and often inflamed vesical mucous membrane, causes the secretion of an abundance of mucus and pus, which, by its alkaline nature, neutralizes the acidity of the urine, or causes it to assume the opposite reaction, a change also promoted by its long retention in the bladder. Hence it is often necessary to give alkalies, even when an alkaline state of the urine would seem to indicate acids.

In the means employed to render the urine alkaline there is considerable choice, and the carbonated alkalies which are usually administered for this purpose, are not the most certain nor the most lasting in their effects. *Liquor potassæ* may be taken in large doses for several days in succession without causing alkalinity of the blood, as was shown by the experiments of Dr. E. A. Parkes, published in the *British and Foreign Medico-Chirurgical Review*, for January, 1853. According to Dr. G. Owen Rees, the most certain and expeditious method of rendering the urine alkaline is to administer the neutral salts formed by the combination of vegetable acids with alkaline bases. Some of these salts are purgative, and others are not so. By making a selection, we may act upon the intestinal canal, the effect upon the urine being the same, contrary to the opinion of those who pretend that when followed by purging they have not sufficient action upon the urine to modify its qualities. The Rochelle powder, a combination of the tartrates of soda and potassa, which has a cathartic effect, produces a well-marked alkaline effect upon the urine. The vegetable acids, when thus combined, undergo a rapid oxydation in the system, and a higher carbonate of the same base is soon formed in the urine. Dr. Rees recommends the tartrate of potassa in the dose of 30 grains to a drachm, two or three times daily. A good suggestion, made by Dr. Owen Rees, is that the alkaline treatment should be employed after the various operations for stone in the bladder. The secretion of urine of even the normal degree of acidity, and

its passage over the inflamed mucous membrane, cannot fail to greatly irritate it, just as happens in gonorrhœa. The citrate of potash in such cases is often of great service.

EFFECT OF CARBONIC ACID ON THE GRAVID UTERUS.

THE *Union Médicale*, for August 12, contains an account of a case in which carbonic acid gas, injected into the vagina, was successfully employed to effect premature delivery. The gas was generated in a glass vessel, by means of the action of acetic acid on the bicarbonate of soda, and conducted into the vagina by means of an elastic tube. A glass speculum was introduced into the vagina, and in order to prevent the carbonic acid from escaping too freely, the tube was passed through a cork which closed the external opening of the speculum. The injection of the acid was followed by a disagreeable pricking sensation in the vagina. After the third application, some pain was felt in the umbilical region, and the cervix uteri became softened. Six applications were made, of from twenty to thirty minutes each, one at night and one in the morning; after the last one, uterine contractions came on, and delivery followed. The result of this case is very satisfactory, so far as it goes, and is worthy of trial in cases where it becomes necessary to procure premature delivery, especially as it occasions no harm either to mother or child, and at the worst only causes the delay of a few days.

DR. BROWN-SÉQUARD.

THE following resolutions were passed subsequently to the close of Dr. Séquard's course of lectures, in this city, by gentlemen of the class.

Resolved, That we have listened with great interest to the instructive lectures of Dr. Ed. Brown-Séquard upon the important subjects to which he so untiringly devotes himself; and that we admire at once his zeal, accuracy, and careful, as well as remarkably successful, experimentation.

Resolved, That we cordially recommend him as a lecturer, to those medical communities in the United States who may thus have an opportunity of acquiring a knowledge of his physiological discoveries and pathological deductions.

MUNIFICENT BEQUEST BY A BOSTON PHYSICIAN.

THE late Dr. Henry Wales, of this city, who died in Paris in June last, has left an extremely valuable collection of books, about fourteen hundred in number, to the library of Harvard College. The collection comprises Sanskrit, German and Italian literature, of the finest editions and elegantly bound, which were purchased by the testator while residing in Europe. By another clause of his will, Dr. Wales appropriated the sum of forty thousand dollars, to be ultimately dedicated to the foundation of a Chair of Sanskrit Literature at the University.

PHYSICIANS' VISITING LIST.

MESSRS. EDITORS,—Under "Bibliographical Notices" in your issue for Oct. 2d, you suggest some alterations in the "Physician's Visiting List," which would certainly be a great improvement in this useful little annual. With a page of the usual size of the diaries on the shelf of every stationer, the object could easily be accomplished. The additional column, for the amount of weekly charges, might be added in the present arrangement, even, by a slight change in the ruling. This, however, is not of as much

importance as space to enter the patient's address. Every physician who pretends to keep a set of books should have a journal as well as ledger; and in this city of Boston, where the credit system prevails to such a ruinous extent, who would pretend to do business without the aid of book-keeping? It were well if this little vade-mecum were all that the practitioner needed; and it might be, were his charges settled as they should be, promptly at each visit, or at least at the termination of each case. In its present form, this little volume is one of the most useful of the long list of Messrs. Lindsay & Blakiston's publications; but with the additions you have hinted at, and another improvement I would suggest, the work could be made still more valuable.

Every physician who has carried the List in his pocket for one year, has found that twelve months' service is too much for the binding in its present form. I have, at one time and another, conversed with quite a number of my professional friends in the city, and all are in favor of more substantial binding—calf or morocco; even strong sheep would do better than the light dress in which it now appears. When the publishers remember that the diary is to be carried in the pocket 365 days, and on every day removed, handled and replaced, perhaps dozens of times, they will at once see the propriety, nay, the absolute necessity of substantial binding. The medical fraternity, who already feel the obligations these gentlemen have placed them under, will doubtless most cheerfully meet the slight additional expense.

DANIEL V. FOLTS, M.D.

38 Maverick Square, November, 1856.

Health of the City.—The ravages of scarlet fever still continue unabated, the large number of 16 deaths having occurred from this cause alone, during the past week. We learn from the City-Registrar that the epidemic is mostly confined to the Irish population, and is of a very malignant character. There were also five deaths from croup. The number of deaths during the corresponding week of 1855 was 65, of which 12 were from consumption, and 1 each from scarlatina and croup.

Books and Pamphlets Received.—On Cystic Entozoa in the Human Kidney. With an illustrative case. By T. Herbert Barker, M.D., F.R.C.S., of Bedford, England. (From the author.)—Proceedings on the occasion of laying the corner-stone of the new Pennsylvania Hospital for the Insane at Philadelphia, including the Address by George B. Wood, M.D.—Gregory's Organic Chemistry. (From the publishers.)—The Unity of Medicine, an Introductory Lecture by Alfred Sillé, M.D., Professor of the Theory and Practice of Medicine in the Pennsylvania Medical College. (From the author.)

MARRIED.—In Melrose, Nov. 20, Sewall F. Parcher, M.D., of East Boston, to Mary E. Libby, of M.—In Pittsfield, Nov. 8th, Dr. Calvin Wetmore, of Illinois, to Mrs. Mary T. Smith, of P.—In Frankfort, Me., Nov. 11th, William R. Stavely, M.D., of Lahaska, Penn., to Miss Julia C. Kelly, of Frankfort.—In Trenton, N. J., Nov. 27th, James W. Stone, M.D., of Boston, to Miss Jennie R. Gillmer, of Trenton.

DIED.—In Dartmouth, Mass., Dr. Wm. B. Mason, aged 74 years.

Deaths in Boston for the week ending Saturday noon, Nov. 29th, 58. Males, 45—females, 43. Asthma, 1—congestion of the brain, 3—burns, 2—consumption, 15—croup, 5—dysentery, 3—dropsy, 3—dropsy in the head, 1—drowned, 1—infantile diseases, 3—hematemesis, 1—exhaustion, 1—typhus fever, 1—typhoid fever, 2—scarlet fever, 16—fracture of the skull, 1—disease of the heart, 4—intemperance, 1—disease of the kidneys, 1—inflammation of the lungs, 3—marasmus, 4—measles, 1—palsy, 1—rheumatism, 1—stoppage of the bowels, 1—scrofula, 1—scalds, 1—teething, 4—unknown, 3—whooping cough, 2—worms, 1.

Under 5 years, 44—between 5 and 20 years, 8—between 20 and 40 years, 18—between 40 and 60 years, 15—above 60 years, 3. Born in the United States, 60—Ireland, 23—other places, 5.

Dr. Kane's Health.—We regret to learn, through the public journals, that Dr. Kane, the celebrated voyager, is in such a delicate state of health, as to render it necessary for him to abandon his home and studies and to seek in a European tour to regain his lost bodily energy. Years ago, when we were intimately associated with the doctor, we knew him to be a great sufferer from a severe organic lesion of the heart, which affliction is doubtless the cause of his present feeble health.—*St. Louis Medical and Surgical Journal.*

Widows and Orphans of Physicians.—The New York Society for the Relief of Widows and Orphans of Medical Men, which eat its annual dinner last Tuesday evening, is now fourteen years old. How it flourishes, may be guessed from its annual statement. The Society was instituted in 1842, and the funds now amount to \$19,911 16, of which \$19,200 is invested in mortgage; the balance will be more than absorbed in a loan lately ordered by the Standing Committee, which waits the necessary investigation of title, and, when completed, will make the Society temporarily indebted to the Treasurer.

The investments draw seven per cent., and are, without exceptions, on improved property in this city and Brooklyn; and, as an additional security, the buildings are all of them insured and the policies assigned.

The receipts for the year ending in September, were \$1,865 12. Disbursements for the same period, \$220 75.

Since the last anniversary dinner fifteen members were elected, making the whole number ninety; of these, fifty-one are for life, and thirty-nine annual subscribers; besides, the number of benefactors have doubled, now numbering eighteen, of whom four are laymen. The Society continues to extend its usefulness to the family of a deceased member.

At the general meeting of the Society in November, members can be proposed and balloted for at the same meeting. Annual members pay an initiation fee of \$10, and \$10 dues in semi-annual payments; or \$100 paid at one time, constitutes a member for life.—*N. Y. Times.*

Sebaceous Tumors.—M. Chassaignac observes, that when sebaceous tumors occur in unexpected localities, he has often found a useful means of diagnosis in observing the exceeding degree of paleness which their surface presents when the base of the tumor is compressed so as to throw this surface into relief; this being much more decided than is the paleness of surface of any other description of tumor submitted to the same procedure.—*Moniteur des Hôpitaux.*

Treatment of Ranula.—M. Gosselin, after alluding to the various modes of treating ranula that have been adopted, and the relapses that are so common after them, describes the plan that he has himself found beneficial. He first of all performs excision, as recommended by Boyer, and then cauterizes with the nitrate of silver. Next day he introduces a probe into the wound, owing to its tendency to close, and repeats the cauterization the day after that. On the third or fourth day he enlarges, by means of the scissors, the aperture, which has become too narrow, and on the following day cauterizes again. After ten or twelve days of this assiduous attention, if on the introduction of a probe he finds the cavity is obliterated, he leaves the opening to itself. If, however, a track of a certain extent still exists, he again enlarges the orifice with scissors. This attention to the case is rarely required beyond fifteen days, when the external opening becomes closed, and the cavity being obliterated, there is no fear of relapse. M. Gosselin has operated in this way in several cases, and in three of these, which he has watched for several years, no relapse has ensued, the opening remaining closed. This plan of procedure has also been extended to various analogous cases, in which there is a cavity with secreting walls, having no spontaneous tendency to approach each other.—*L'Union Médicale.*

Mr. Dallas, of Odessa, states, in confirmation of the observations already published by Taddei, Marchal, and others, that the injection of the balsam of copaiba is the most efficacious mode of treating gonorrhœa:—In sixteen cases he has so employed it, using no internal remedy, either in recent or old gonorrhœa, with complete success. His formula is copaib., five drachms; one yolk of egg; gummy extract of opium, one grain; water, seven ounces. The injection should be used several times a day.—*Gaz. des Hôpitaux.*